P.O. Box 8730
Madison, WI 53708-8730

www.triwest.com

Date: ______/______/______

Dear Provider,

To become an authorized TRICARE provider or update your certification, please complete and return all applicable forms within 30 days. Failure to comply within 30 days will result in denial of your TRICARE claims.

Complete the enclosed forms (if applicable)

1. Clinic or Group Application.
2. Mental Health Questionnaire. To provide complete information about your organization. (Enclosed if applicable)
3. Signatures: (check one of the following options)
   - ❑ Your staff may sign TRICARE claim forms on your behalf when the necessary Authorized Signer form has been completed.
   - ❑ Computer Generated Facsimile or Rubber Stamp Authorization may also be used when the necessary agreement is on file. Computer generated "Signature on file" is not acceptable.
   - ❑ An original signature by the individual provider.
4. Special Authorization form should be completed by all members of your professional staff if payment is being made in the name of the organization (i.e., clinic, group, or partnership) or you can attach your own listing.
5. Complete the Individual Provider Application Forms that apply.

   Send a copy of your state license and/or certificate of membership in the appropriate National Professional Organization. If you are not a member of the National Organization, please include a copy of transcripts and a resume of your supervised experience to document your eligibility. As your license is renewed, please send in an updated copy.
6. Complete W-9.

Thank you for your cooperation and prompt response.

Sincerely,

WPS Tricare Provider Certification Unit

Please return to: WPS TRICARE Provider Certification
P.O. Box 8730
Madison, WI 53708-8730

Please feel free to photocopy any of the enclosed forms as needed.

17281-097-0411

PASTORAL COUNSELOR PROVIDER FILE APPLICATION

FAILURE TO COMPLETE AND SIGN THIS CERTIFICATION WILL RESULT IN DENIAL OF FUTURE CLAIM PAYMENT

Date of Request _____ /_____ /_____

Name ____ Telephone # (_____) ______________________________

Social Security # __________________________________ Federal Tax ID # __________________________________

National Provider Identifier (NPI) #___________________

Office location (Street address): **Billing address** (if different):

____ ____

____ ____

____ ____

Are you joining an established group practice? ❑ Yes ❑ No

If Yes: Group name _______________________________ Provider #_______________________________________

You must complete the Reassignment of Benefits form if the group will bill on your behalf.

Date you began filing with the group provider #: _____ /_____ /_____

Do you maintain a solo practice? ❑ Yes ❑ No

Are you: **Location:**

Hospital employed or contracted? ❑ Yes ❑ No _______________________________________

Teaching setting? ❑ Yes ❑ No _______________________________________

Employed by the U.S. Government? ❑ Yes ❑ No _______________________________________

LICENSE # _____________________________________ ❑ Temporary

Date license was first issued _____ /_____ /_____ ❑ Permanent Issuing state ______________________

Expiration Date _____ /_____ /_____ Dates are mandatory and must be updated when renewed.

Medicare #_______________________________________

—OVER—

P.O. Box 8730 Madison, WI 53708-8730

The services of pastoral counselors are coverable on a fee-for-service basis if the beneficiary is referred by a physician and the physician is providing on-going oversight and supervision of the services being provided.

The provider must belong to the American Association of Pastoral Counselors.

In addition, pastoral counselors must have a recognized graduate professional education with the minimum of an earned master's degree from an accredited educational institution in an appropriate behavioral science field or mental health discipline. Please complete the Course of Study form and enclose copies of your transcripts.

Name and location of school: ____

____

____

____

Degree earned ____

Year earned ____

Field of study ____

One of the following experience requirements must also be met:

A. 200 hours of approved supervision of the practice of marriage and family counseling, ordinarily to be completed in a 2 to 3 year period, of which at least 100 hours must be in individual supervision. The supervision will occur preferably with more than one supervisor, with at least three cases and 1,000 hours of clinical experience in the practice of marriage and family or pastoral counseling under approved supervision involving at least 50 different cases.

B. 150 hours of approved supervision of the practice of psychotherapy, ordinarily to be completed in a 2 to 3 year period, of which at least 50 hours must be individual supervision. The supervision will occur preferably with more than one supervisor, with at least three cases and 1,000 hours of clinical experience in the the practice of marriage and family or pastoral counseling under approved supervision involving at least 50 different cases.

I certify that I have completed at least the number of hours of practice required in: ❑ A. ❑ B.

Signature ____

CONFLICT OF INTEREST STATEMENT

For TRICARE providers:

Federal law (5 U.S.C. 5536) prohibits medical personnel, who are active duty members or civilian employees of the government, compensation above their normal pay and allowances for medical care rendered. This prohibition applies to TRICARE benefits whether the claim for reimbursement is filed by the individual who provided the care, the facility in which the care was rendered, or by the sponsor/beneficiary. Claims for TRICARE benefits will be denied in any situation where either a uniform member or civilian employee of the uniform services has the opportunity to exert, directly or indirectly, any influence on the referral of TRICARE beneficiaries to one or more providers on a selective basis.

Please return to: WPS TRICARE Provider Certification
P.O. Box 8730
Madison, WI 53708-8730

Please notify us of any changes related to your provider file information (name, address, specialty, tax number, group affiliations, etc.).

MENTAL HEALTH CARE PROVIDER QUESTIONNAIRE/PROVIDER FILE APPLICATION

Please complete and return this questionnaire regarding your Mental Health organization.

1. A copy of your organization's state license or certification (if required by state statutes).
2. Our organization is funded by: ❑ State government ❑ Federal government ❑ Neither
3. Who owns and operates your facility?
   NAME ______________________________
   ADDRESS ______________________________
   CITY ______________________ STATE __________ ZIP
   COUNTY ____________________ OTHER ____________________
   ❑ PRIVATE ❑ PROFIT ❑ NON PROFIT
4. Our Federal Tax Identification number is______________________________
   This number is issued under the following name: ______________________________
   ____
5. Listing of services provided by your organization:
   ❑ In Patient ❑ Out Patient ❑ Other (**Explain, using back of this form**)
6. If providing inpatient services, is your facility JCAHO accredited?
   ❑ YES ______________________ ❑ NO
   Effective Date
7. Please provide a listing of all providers of services within your organization.
8. Are you Medicare certified? ❑ YES ❑ NO If so, the effective date ____________________
9. Name and telephone number of individual to be contacted in the event further clarification is required.

Name ______________________________ Telephone number ________________

I have completed this questionnaire to the best of my ability and knowledge and certify it is true and correct.

Signature ______________________________ Date ____________________

Printed name ______________________________ Title ____________________

Please return your response in the envelope provided. Thank you for your cooperation.

If you have any questions, please call (608) 301-2444.

Please return to: WPS TRICARE Provider Certification
P.O. Box 8730
Madison, WI 53708-8730

18423-097-0403

Administered By:

P.O. Box 8730 Madison, WI 53708-8730

PASTORAL COUNSELOR AND MARRIAGE AND FAMILY THERAPIST COURSE OF STUDY

This course of Study Form must be filled out completely and returned with a copy of your school transcript for review and verfication to:

WPS TRICARE Provider Certification Unit
P.O. Box 8730
Madison, WI 53708-8730

Human Development (3 courses minimum). Human development, personality theory, human sexuality, psychopatholgy-behavior pathology.

Course Titles	Institution	Dates From/To	Credit Hrs. or	Contact Hrs.
1)				
2)				
3)				

Marital and Family Studies (3 courses minimum). Family development, family systems, marital, sibling and individual subsytems.

Course Titles	Institution	Dates From/To	Credit Hrs. or	Contact Hrs.
1)				
2)				
3)				

Marital and Family Therapy (3 courses minimum). Major marital and family treatment approaches, e.g., systems, behavioral, neonalytic (object relations), structural, communications.

Course Titles	Dates Institution	Credit From/To	Contact Hrs. or	Hrs.
1)				
2)				
3)				

- OVER -

Administered By:

P.O. Box 8730 Madison, WI 53708-8730

Research (1 course minimum). Research design, methodology, statistics, research in marital and family studies therapy.

Course Titles	Institution	Dates From/To	Credit Hrs. or	Contact Hrs.

Professional Studies (1 course minimum). Ethics, family law.

Course Titles	Institution	Dates From/To	Credit Hrs. or	Contact Hrs.

Practicum (Supervised Clinical Practice). One year minimum doing graduate work is required: Fifteen hours per week, approximately 8-10 hours in direct clinical contact with individuals, couples and families.

Course Titles	Institution	Dates From/To	Total Hours of Practicum

A. EDUCATION Fill out in detail the information requested below, beginning with undergraduate college education.

Name of Institution	Major Area of Study	Dates Attended From/To	Degree Obtained	Date

I certify the above information to be true and complete to the best of my knowledge.

Name

Date

Printed Name

Title

P.O. Box 8730
Madison, WI 53708-8730

www.triwest.com

If a provider elects to use a facsimile signature (rubber stamp) or allow a representative to sign her/his name for certification of the services rendered, it is a TRICARE requirement that we have authorization from the provider.

Please complete the requested information on the authorization form below and return it to our office to assure prompt adjudication of your claims. Thank you.

AUTHORIZED SIGNER

Hospital/Clinic Name: ______________________________ Hospital/Clinic IRS Tax Number: ______________

Address: ______________________________ City, State, Zip: ______________________________

Each of the below named representatives of this organization are hereby authorized to complete and sign all claim forms required by TRICARE and any related documentation that might be required by fiscal administrators of TRICARE on behalf of all physicians, dentists and other allied science professional staff members for authorized services, care and treatment rendered in the hospital or clinic to TRICARE patients.

The undersigned understands that this is continuing authorization and that the data on such claim forms is entered with the same authority, accuracy and effect as though executed by a member of the professional staff on whose behalf the form is completed. We understand that this authorization shall remain in effect until cancelled or modified in writing by the undersigned.

The agents' signatures, typed names and official titles with the organization as authorized above, are as follows:

____

Signature Printed Name Official Title

____

Signature Printed Name Official Title

____

Signature of President (or other authorized officer of the governing body of the hospital, clinic, or association.) Date

COMPUTER GENERATED FACSIMILE OR RUBBER STAMP AUTHORIZATION

Name: ______________________________ SSN: ____________________ IRS Tax#: ____________

Address: ______________________________ City, State, Zip: ______________________________

______________________________ being first duly sworn, deposes and says: I hereby authorize Wisconsin Physicians Service Insurance Corporation to accept my facsimile or stamp signature, shown below, as my true signature for all purposes under the TRICARE program in the same manner as if it were my actual signature.

______________________________ ______________________________

Actual Signature (Facsimile or Stamp Signature)

Subscribed and sworn to before me this ____________ (date) day of ____________________ (month), 20 ____ .

NOTARY PUBLIC IN AND FOR ______________________________________

county, state of ____________________ , my commission expires ____________ (SEAL)

- OVER -

CONFLICT OF INTEREST STATEMENT

For TRICARE providers:

Federal Law (5 U.S.C. 5536) prohibits medical personnel who are active duty members or civilian employees of the government to receive compensation above their normal pay and allowances for medical care rendered. This prohibition applies to TRICARE benefits whether the claim for reimbursement is filed by the individual who provided the care, the facility in which the care was rendered, or by the sponsor/beneficiary. Claims for TRICARE benefits will be denied in any situation where either a uniform member or civilian employee of the uniform services has the opportunity to exert, directly or indirectly, any influence on the referral of TRICARE beneficiaries to one or more providers on a selective basis.

Please return to: WPS TRICARE Provider Certification
P.O. Box 8730
Madison, WI 53708-8730

Please notify us of any changes related to your provider file information (name, address, specialty, tax number, group affiliations, etc.).

Dear TRICARE Provider,

Are you looking for a paperless solution to preparing your claims? With health care costs at an all time high, filing claims electronically is a proven way to lower your administrative costs and greatly relieves a burdensome, paper-intensive administration system.

Wisconsin Physicians Service currently processes TRICARE claims electronically for the states of Alaska, Arizona, California, Colorado, Hawaii, Idaho, Iowa, Kansas, Minnesota, Missouri, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oregon, South Dakota, Utah, Washington, Wyoming and Texas (western), as a sub-contractor to TRIWEST.

We encourage you to take advantage of one of our electronic claims submission options. Electronic Data Interchange (EDI) can offer you:

- ❑ **Faster Claim Processing**
- ❑ Lower administrative costs
- ❑ Reduction in postage costs and mailing time
- ❑ Immediate verification of claims received
- ❑ Greater data accuracy
- ❑ Elimination of paper handling

To learn more about the exciting world of electronic claim filing and the EDI options available to your office, please contact us at:

WPS Electronic Data Services
1717 W. Broadway
P.O. Box 8128
Madison, WI 5378

Toll Free: 1 - (800) 782-2680
1 - (608) 221-7115
FAX: (608) 223-3824

You can also visit our website at ***http://www.wpsic.com/provider/edi_home.html.***

We look forward to talking with you about your TRICARE claim submission options.

Sincerely,

WPS TRICARE Electronic Data Services

20725-097-0403

Form **W-9**
(Rev. January 2002)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give form to the requester. Do not send to the IRS.

Print or type
See **Specific Instructions** on page 2.

Name

Business name, if different from above

Check appropriate box: ☐ Individual/ Sole proprietor ☐ Corporation ☐ Partnership ☐ Other ▶ ------------------ ☐ Exempt from backup withholding

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. For individuals, this is your social security number (SSN). **However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 2.** For other entities, it is your employer identification number (EIN). If you do not have a number, see **How to get a TIN** on page 2.

Note: *If the account is in more than one name, see the chart on page 2 for guidelines on whose number to enter.*

Social security number

or

Employer identification number

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), **and**
2. I am not subject to backup withholding because: **(a)** I am exempt from backup withholding, or **(b)** I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or **(c)** the IRS has notified me that I am no longer subject to backup withholding, **and**
3. I am a U.S. person (including a U.S. resident alien).

Certification instructions. You must cross out item **2** above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item **2** does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (See the instructions on page 2.)

Sign Here **Signature of U.S. person ▶** **Date ▶**

Purpose of Form

A person who is required to file an information return with the IRS must get your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to give your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify the TIN you are giving is correct (or you are waiting for a number to be issued),

2. Certify you are not subject to backup withholding, or

3. Claim exemption from backup withholding if you are a U.S. exempt payee.

If you are a foreign person, use the appropriate Form W-8. See **Pub. 515,** Withholding of Tax on Nonresident Aliens and Foreign Entities.

Note: *If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.*

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 30% of such payments **after** December 31, 2001 (29% **after** December 31, 2003). This is called "backup withholding." Payments that may be subject to backup withholding include interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will **not** be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester, or

2. You do not certify your TIN when required (see the Part II instructions on page 2 for details), or

3. The IRS tells the requester that you furnished an incorrect TIN, or

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the instructions on page 2 and the separate **Instructions for the Requester of Form W-9.**

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of Federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Name. If you are an individual, you must generally enter the name shown on your social security card. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first and then circle the name of the person or entity whose number you enter in Part I of the form.

Sole proprietor. Enter your **individual** name as shown on your social security card on the "Name" line. You may enter your business, trade, or "doing business as (DBA)" name on the "Business name" line.

Limited liability company (LLC). If you are a single-member LLC (including a foreign LLC with a domestic owner) that is disregarded as an entity separate from its owner under Treasury regulations section 301.7701-3, **enter the owner's name on the "Name" line.** Enter the LLC's name on the "Business name" line.

Other entities. Enter your business name as shown on required Federal tax documents on the "Name" line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the "Business name" line.

Exempt from backup withholding. If you are exempt, enter your name as described above, then check the "Exempt from backup withholding" box in the line following the business name, sign and date the form.

Individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends. For more information on exempt payees, see the Instructions for the Requester of Form W-9.

If you are a nonresident alien or a foreign entity not subject to backup withholding, give the requester the appropriate completed Form W-8.

Note: *If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding.*

Part I—Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box.

If you are a **resident alien** and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see **How to get a TIN** below.

If you are a **sole proprietor** and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are an **LLC** that is **disregarded as an entity** separate from its owner (see ***Limited liability company (LLC)*** above), and are owned by an individual, enter your SSN (or "pre-LLC" EIN, if desired). If the owner of a disregarded LLC is a corporation, partnership, etc., enter the owner's EIN.

Note: *See the chart on this page for further clarification of name and TIN combinations.*

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get **Form SS-5,** Application for a Social Security Card, from your local Social Security Administration office. Get **Form W-7,** Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or **Form SS-4,** Application for Employer Identification Number, to apply for an EIN. You can get Forms W-7 and SS-4 from the IRS by calling 1-800-TAX-FORM (1-800-829-3676) or from the IRS Web Site at **www.irs.gov**.

If you are asked to complete Form W-9 but do not have a TIN, write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note: *Writing "Applied For" means that you have already applied for a TIN **or** that you intend to apply for one soon.*

Caution: *A disregarded domestic entity that has a foreign owner must use the appropriate Form W-8.*

Part II—Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if items 1, 3, and 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). Exempt recipients, see ***Exempt from backup withholding*** above.

Signature requirements. Complete the certification as indicated in **1** through **5** below.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item **2** in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item **2** of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA or Archer MSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to give your correct TIN to persons who must file information returns with the IRS to report interest, dividends, and certain other income paid to you, mortgage interest you paid, the acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA or Archer MSA. The IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. The IRS may also provide this information to the Department of Justice for civil and criminal litigation, and to cities, states, and the District of Columbia to carry out their tax laws.

You must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold 30% of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to a payer. Certain penalties may also apply.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account [1]
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor [2]
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee [1]
b. So-called trust account that is not a legal or valid trust under state law	The actual owner [1]
5. Sole proprietorship	The owner [3]
For this type of account:	**Give name and EIN of:**
6. Sole proprietorship	The owner [3]
7. A valid trust, estate, or pension trust	Legal entity [4]
8. Corporate	The corporation
9. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
10. Partnership	The partnership
11. A broker or registered nominee	The broker or nominee
12. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity

[1] List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

[2] Circle the minor's name and furnish the minor's SSN.

[3] **You must show your individual name,** but you may also enter your business or "DBA" name. You may use either your SSN or EIN (if you have one).

[4] List first and circle the name of the legal trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.)

Note: *If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.*